SECTION 8000
FUNDING OF MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

Hospitals operated by State government or local government units where there is a Medicaid deficit (i.e., the cost of providing services to Wisconsin Medicaid recipients exceeds the payments for those services) and a total hospital operating deficit qualify to receive funding from the Wisconsin Medicaid program to the extent that sufficient State appropriation or local tax-generated government funds are available to match all or a portion of this deficit, not to exceed 100%, and which are not otherwise claimed as match for any federal program. The Wisconsin Medicaid program will reimburse a facility, which meets the above criteria, an amount equivalent to the federal financial participation (FFP) but not to exceed the amount for which state or local funds are available to serve as matching funds for the FFP. However, the sum of the FFP equivalent amount which the Wisconsin Medicaid program reimburses the facility and the state or local matching funds shall not exceed the facility's inpatient Medicaid deficit or total operating deficit, whichever is the lesser deficit amount. Hospital revenue realized under section 8200 shall not be recognized in the determination of the facility's inpatient Medicaid deficit. In addition, the total FFP equivalent amount which the Wisconsin Medicaid program reimburses qualifying facilities shall not exceed the lesser of $3,300,000 annually or the amount for which FFP is available under federal upper-payment limits of 42 CFR 447.272(a) and (b). In the event of a federal disallowance, the Department will recoup FFP monies paid to the facilities under this provision.

APPLICATION OF CHARGE LIMITATION

The FFP equivalent amount which the Wisconsin Medicaid program reimburses a qualifying hospital plus the required amount of local matching funds may not exceed the amount by which "net charges exceed payments" for the settlement period. "Net charges exceeding payments" is the amount by which allowable charges-plus-disproportionate share exceed overall payments to the hospital from all sources for inpatient hospital services provided to WMAP recipients with overall payments not including the FFP equivalent amount which the Wisconsin Medicaid program reimburses a qualifying hospital under this section plus the required amount of local matching funds required under this section. The settlement period is the fiscal year of the hospital for which funding of the hospital's Medicaid deficit is being determined. The Department may use a partial year if the full fiscal year period is not available for the hospital. Overall payments from all sources is described in §9000. This limitation shall begin to be applied for any settlement period (or hospital fiscal year) which begins on or after July 1, 1994.

HOSPITAL MUST REQUEST FUNDING

For a government hospital's fiscal years ending after July 1, 1998, the hospital must submit a written request to the Department for deficit funding under this section. The Department will determine if a hospital qualifies for deficit funding if and only if the hospital submits such written request. The request must: (a) specify the hospital and the fiscal year for which deficit funding is requested; (b) must be delivered to the Department within nine (9) months after completion of the fiscal year; and (c) may not be delivered to the Department before the end of the fiscal year for which deficit funding is requested.

SECTION 8100
SUPPLEMENTAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)

Supplemental payments are provided for any hospital located in Wisconsin which meets the criteria for an "essential access city hospital" (EACH). The payments will be subject to the payment limitation of section 9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for covered services.

8110 Qualifying Criteria for EACH Supplement

A hospital qualifies for an EACH supplement in a rate year if the hospital met the following criteria during the year July 1, 1995 through June 30, 1996.

1) The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
2) At least 30% of the hospital's Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
3) More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
   (a) including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance
   (b) but not including days of Medicaid recipients' stays that are covered in full or part by Medicare.
4) The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

8115 Determination of EACH Supplement

The EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the EACH supplement is limited to $4,448,000 annually. This is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's EACH supplement will be determined as follows:

$$\text{Hospital's Annual EACH Supplement} = \frac{\text{Medicaid days for hospital}}{\text{Sum of Medicaid days of qualifying hospitals}} \times \$4{,}448{,}000 \text{ Statewide annual funding}$$

$$\text{Hospital's Monthly EACH Supplement} = \frac{\text{Hospital's Annual EACH Supplement}}{12 \text{ Months}}$$

Medicaid days are a hospital's total covered inpatient days for Medicaid recipients for the calendar year prior to the rate year for which the EACH supplement is being calculated. The days include Medicaid HMO covered days and Medicaid covered days on which Medicaid made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of Medicaid recipient stays that are covered in full or part by Medicare.

8130 Sanction on Not Continuing To Meet Qualifying Criteria

A hospital receiving an EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a rate year, the monthly supplement of other qualify hospitals will not be recalculated to redistribute the total annual funding for the EACH supplement.

Substitute Page

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SECTION 8200
INPATIENT INDIGENT CARE ALLOWANCE and GENERAL ASSISTANCE DISPROPORTIONATE SHARE SUPPLEMENT

Supplement Medicaid payments are provided to hospitals that provide a significant quantity of services to low-income persons covered by a county administered general assistance (GA) program and to Wisconsin Medicaid recipients. These supplements are the indigent care allowance and the general assistance disproportionate share supplement. The identifying of services a hospital provides to persons covered by a county general assistance program is a reliable method for identifying the quantity of services a hospital provides low-income persons other than Medicaid recipients. Persons may be eligible for county administered general assistance under financial income criteria similar to or more restrictive than those for the Wisconsin Medicaid Program.

8210 Qualifying Criteria.

For a hospital to qualify for an indigent care allowance and/or disproportionate share supplement,

(1) at least 15% of the hospital's operating expenses must be attributable to inpatient and outpatient services provided persons eligible under the Wisconsin Medicaid Program and to low-income persons covered by a general assistance program administered by a county as determined under §8215,

(2) at least 5% of the hospital's operating expenses must be attributable to inpatient and outpatient services provided persons covered by a general assistance program administered by a county as determined under §8215, and

(3) a hospital that is not owned and operated by a county government must have a contract with a county government to provide medical services to low-income persons covered by the county's general assistance program, and

(3) to qualify for GA disproportionate supplement under §8250, the hospital must qualify for a disproportionate share adjustment under §5240.

8215 Calculation of Qualifying Percentage for Specific Hospital

The percent of operating expenses attributable to services provided to the low-income persons is determined as follows. Section 8260 discusses the historical financial data to be used for a hospital which has combined with the operation of another hospital.

MAFFSIN MAFFSOUT	Total fee-for-service charges by the hospital to the Wisconsin Medicaid Program (WMP) for inpatient and outpatient provided services WMP recipients in the calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
MAHMOIN MAHMOOUT	For inpatient and outpatient services provided WMP recipients covered by Medicaid HMO or managed care contractors, total charges by the hospital in the hospital's fiscal year that ended in the calendar year prior to the July 1 rate year. If charges not available, zero will be used. For example, for rate year beginning July 1, 1997, the hospital's fiscal year that ended in 1996 would be used.
GAIN GAOUT	Total charges by the hospital for inpatient and outpatient services provided persons covered by a county administered general assistance program (GA) in the calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
RCC	The ratio of the hospital's overall costs to overall charges for hospital patient services, not to exceed 1.00, as determined from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
TOTEXP	Total hospital patient care expenses from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
MAEXPIN MAEXPOUT	Total expenses attributed to inpatient and outpatient hospital services provided to WMP recipients calculated as: *MAEXPIN = (MAFFSIN + MAHMOIN) x RCC And MAEXPOUT = (MAFFSOUT + MAHMOOUT) x RCC*
GAEXPIN GAEXPOUT	Total expenses attributed to inpatient and outpatient hospital services provided persons covered by a GA program adminstered by a county calculated as: *GAEXPIN = GAIN x RCC And GAEXPOUT = GAOUT x RCC*
GAPERC	Percent of hospital's operating expenses attributable to services provided persons covered by a GA program adminstered by a county calculated as: *GAPERC = (GAEXPIN + GAEXPOUT) / TOTEXP*
TOTPERC	Percent of hospital's operating expenses attributable to services provided persons covered by (a) a GA program administered by a county and (b) the Wisconsin Medicaid Program (WMP) calculated as: *TOTPERC = (GAEXPIN + GAEXPOUT + MAEXPIN + MAEXPOUT) / TOTEXP*

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Not to be included in charges are those charges made by the hospital to county administered programs required by state statute for the prevention or amelioration of mental disabilities and for the provision of services to developmental disabled persons and their families. (i.e., programs required or authorized under Wis Stats, §51.42 and §51.437.)

8230 Calculation of Inpatient Indigent Care Allowance

An inpatient indigent care allowance is calculated for each qualifying hospital as formulated below based on its expenses attributed to inpatient services provided to low-income persons covered by a county administered general assistance (GA) program. Section 8260 discusses the historical financial data to be used for any hospital which has combined with the operation of another hospital.

GAEXPIN	For each qualifying hospital, expenses attributable to inpatient services provided to low-income persons covered by a county administered GA program as determined under §8215.
CHGEXCESS	The amount by which fee-for-service charges by the hospital to the WMP for inpatient services exceeds the fee-for-service amount paid by the WMP to the hospital for the charged services, with the difference reduced by 5%. The amount paid means payments to the hospital from the WMP, excluding payments from sources other than the WMP and excluding GA-DSH supplemental payments and indigent care allowance payments . The charges and payments used are from calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
LESSER	For each qualifying hospital, the lesser amount of GAEXPIN or CHGEXCESS
$\sum$LESSER	The sum of LESSER for all qualifying hospitals.
TOTMAX	The maximum funding to be distributed which is the lesser of: (1) the inpatient indigent care allowance funding target specified in §8270 or (2) the sum of the LESSER amounts of all qualifying hospitals ($\sum$LESSER).
RATIO	The ratio of each qualifying hospital's LESSER amount to $\sum$LESSER which is calculated as: *RATIO = LESSER / $\sum$LESSER* (The sum of the ratios for all qualifying hospitals must equal 1.00.)
ICA	The annual inpatient indigent care allowance for each qualifying hospital calculated as: *ICA = RATIO x TOTMAX*

The above calculations assure that a hospital's indigent care allowance does not exceed its expenses attributable to inpatient services provided general assistance recipients. They also assure that indigent care allowances in total do not exceed the funding available to the WMP.

8235 Payment of Inpatient Indigent Care Allowances

The annual inpatient indigent care allowance calculated above for each qualifying hospital, divided by twelve, is the amount paid to the hospital for each month of the rate year.

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8250 General Assistance Disproportionate Share Supplement

A general assistance disproportionate share supplement (GADSH)is calculated for each qualifying hospital in a step-wise distribution method in which the following are amounts are used.

ICA	The annual inpatient indigent care allowance for each qualifying hospitalas calculated under §8230 .
GAEXPIN	For each qualifying hospital, expenses attributable to inpatient services provided to low-income persons covered by a county administered GA program as determined under §8215.
EXCESS	The amount by which a qualifying hospital's GAEXPIN exceeds the amount the hospital is to receive through the inpatient indigent care allowance (ICA), calculated as: *EXCESS = GAEXPIN - ICA*
$\sum$EXCESS	The sum of EXCESS for all qualifying hospitals.
MAXDSH	The maximum amount of disproportionate share funding to be distributed which shall be the lesser of: (1) the total GADSH target funding specified in §8272 or (2) the above $\sum$EXCESS.
ICAPERC	The percentage of each hospital's GAEXPIN that is covered by the inpatient indigent care allowance, calculated as: *ICAPERC = ICA / GAEXPIN*
GA-DSH	A hospital's annual general assistance disproportionate share allowance as determined according to the step-wise distribution method described below.

8252 Step-Wise Distribution Method For General Assistance Disproportionate Share Supplement

The limited funding of the GA-DSH supplement will be distributed among hospitals in the step-wise distribution method described below. *The total amount each hospital receives through this GA-DSH supplement and the inpatient indigent care allowance (ICA) will not exceed the hospitals's inpatient expenses for GA recipients (GAEXPIN).*

The indigent care allowance (ICA) calculated in §8230 may cover a larger portion of one hospital's GA inpatient expense than that covered for another hospital. This lower rate of coverage can result from the hospital being limited by charges in calculating the indigent care allowance. The step-wise distribution process of the GADSH funding target can equalize, or at least narrow, such differences between hospitals.

The "ICAPERC" is the percentage of each hospital's GA inpatient expense that is covered by the inpatient indigent care allowance. Hospitals are ranked according to their ICAPERC with the hospital with the lowest ICAPERC assigned rank 1, second lowest ICAPERC assigned rank 2, third lowest ICAPERC assigned rank 3 and continuing until all hospitals are ranked from the lowest to the highest ICAPERC.

Beginning with the lowest ICAPERC hospital (rank 1), GA-DSH funds are prorated to the hospital until the percent of their covered GA inpatient expense (GAEXPIN) equals the ICAPERC of the second lowest (rank 2) hospitals. Then, for the rank 1 and rank 2 hospitals, GA-DSH funds are prorated until the percent of their covered GA expense is equal to the ICAPERC of the rank 3 hospital. Thirdly, for the rank 1, 2 and 3 ICAPERC hospitals, GA-DSH funds are prorated until the percent of their covered GA expense equal the ICAPERC of the rank 4 hospital.

As the available funds are distributed through the ranks of hospitals, the distribution is stopped when all available funds are distributed (MAXDSH).

However, some GA-DSH funds may remain when the step-wise distribution is completed for all hospitals. These remaining funds are distributed among all qualifying hospitals based on the amount of each hospital's GA inpatient expense that are not covered by the indigent care allowances and the GA-DSH distribution.

An example of the above distribution method is shown below in §8270 using four hospitals.

8253 Payment of General Assistance Disproportionate Share Supplement

The annual general assistance disproportionate share supplement calculated above for each qualifying hospital is distributed between the first period and second period described in §8272, divided by the number of months in each period, resulting in the amount that will be paid to the hospital each month of the period. The following formulae describe the calculation.

MONTH1	The number of months in the first period.
MONTH2	The number of months in second period.
CEILING1	GADSH funding specified in §8272 for the first period of the rate year.
CEILING2	GADSH funding specified in §8272 for the second period of the rate year.
DSHCEILING	Total annual funding specified in §8272 for the rate year (i.e., sum of CEILING1 & CEILING 2).
GADSH	A hospital's annual general assistance disproportionate share supplement as determined above in §8252.
SUPP1	Supplement to be paid for each month of the first period calculated as: *SUPP1 = (CEILING1 / DSHCEILING) X GADSH / MONTH1*
SUPP2	Supplement to be paid for each month of the second period calculated as: *SUPP2 = (CEILING2 / DSHCEILING) X GADSH / MONTH2*

8260 Combining Historical Financial Statistics for Recent Hospital Combinings

Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant.

When hospitals combine into one hospital, the required years of historical data may not be available for the combined operation for one or more rate years after the combining occurs . Whenever a required year of data is available for a full year of the combined hospital operation, then that year of data is used. However, if a full year is not available for the combined operation, then data of the individual hospitals for the required years is combined or added together for the calculations under §8200 through §8252.

8270 Indigent Care Allowance Target Funding.

For the rate year July 1, 1999 through June 30, 2000 , the total target funding for the inpatient indigent care allowance is $5,454,998 .

For the rate year July 1, 2000 through June 30, 2001 , and each rate year thereafter, the total target funding for the inpatient indigent care allowance is $5,454,998 .

8272 GA Disproportionate Share Supplement (GADSH) Target Funding

For the rate year July 1, 1999 through June 30, 2000, the target funding for the general assistance disproportionate share supplement is $5,672,100 .

For the rate year July 1, 2000 through June 30, 2001 , and each year thereafter, the target funding for the general assistance disproportionate share supplement is $5,280,000.

The total amount to be paid to qualifying hospitals for GA disproportionate share supplements is not to exceed the amount of the disproportionate share funding ceiling for each federal fiscal year ending September 30th that is assigned to the WMP under 42 CFR 447.296 through 447.299, reduced for disproportionate share hospital payments under §5240.

Based on current estimates of the federal funding ceiling available for this supplement, the following amounts will be used. These amounts will be reduced if ceiling amounts provided by the federal Health Care Financing Administration under 42 CFR 447.296 through 447.299 do not provide sufficient funding for disproportionate share payments of §5240 and this section.

The funding targets for the rate year July 1, 1999 through June 30, 2000 are:

First Period	$ 1,712,100	For the fourth quarter of federal fiscal year ending September 30, 1999 , that is, the three months July 1, 1999 through September 30, 1999 .
Second Period	$3,960,000	Combined amount for the first three-quarters of federal fiscal year ending September 30, 2000, that is, the nine months October 1, 1999 through June 30, 2000 .
Annual Total	$5,672,100	

The funding targets for the rate year July 1, 2000 through June 30, 2001 , and each rate year thereafter are:

First Period	$1,320,000	For the fourth quarter of federal fiscal year ending September 30 during the rate year, that is, the three months July through September.
Second Period	$3,960,000	Combined amount for the first three quarters of the federal fiscal year that ends the September 30th after the end of the rate year, that is, the nine months October through June.
Annual Total	$5,280,000	

8290 Example, Step-wise Distribution of GA-DSH Funding

	Hospital	A	B	C	D	TOTALS
1	Inpatient Indigent Care Allowance (ICA)	$10,710	$0	$5,290	$4,320	
2	Divide by: Hospital's Inpatient GA expense	$17,000	$4,000	$23,000	$12,000	
3	ICA Percentage Line 1 / Line 2	63.0%	0.0%	23.0%	36.0%	
4	Assigned Priority Rank Number (lowest to highest)	#4	#1	#2	#3	
5	Target funding for GA-DSH supplement					$7,000
6	**STEP 1**					
7	GA expense from line 2 for hospitals with #1 priority rank	$4,000				
8	Times: ICA percentage from line 3 for #2 hospitals		23.0%			
9	Product of Line 7 x Line 8		$920			
10	Subtract: Total indigent care allowances from line 1		0			
11	Step 1 DSH proration, Line 9 - Line 10		$920			($920)
12	Remaining MAXDSH, Line 5 - Line 11					$6,080
13	**STEP 2**					
14	GA expense from line 2 for hospitals with #1 & #2 priority rank		$4,000	$23,000		
15	Times: ICA percentage from line 3 for #3 hospitalsv		36.0%	36.0%		
16	Product of Line 14 x Line 15		$1,440	$8,280		
17	Subtract: Total indigent care allowances from line 1		$0	($5,290)		
18	Subtract: DSH prorated in step 1, from line 11		($920)	$0		
19	Step 2 DSH proration, Line 16 - Lines 17 & 18		$520	$2,990		
20	Total DSH prorated at line 19					($3,510)
21	Remaining MAXDSH, Line 12 - Line 20					$2,570
22	**STEP 3**					
23	GA expense from line 2 for hospitals with #1, #2 & #3 priority rank		$4,000	$23,000	$12,000	
24	Times: ICA_PERC from line 3 for #4 hospitals		63.0%	63.0%	63.0%	
25	Product of Line 23 x Line 24		$2,520	$14,490	$7,560	
26	Subtract: Total indigent care allowances from line 1		$0	($5,290)	($4,320)	
27	Subtract: DSH prorated in step 1, from line 11		($920)	$0	$0	
28	Subtract: DSH prorated in step 2, from line 19		($520)	($2,990)	$0	
29	Step 3 DSH proration, Line 25 - Lines 26, 27, 28		$1,080	$6,210	$3,240	
30	Total DSH prorated at line 29					($10,530)
31	Remaining MAXDSH, Line 21 - Line 30					($7,960)
32	**STEP 4**					
33	**IF remaining MAXDSH is Minus amount**:					
34	The minus MAXDSH from line 31					($7,960)
35	Divide by: DSH prorated to hospitals from line 30					($10,530)
36	Percentage by which to cutback DSH prorated at line 29.					75.59%
37	Amount to subtract from prorated DSH, Line 36 x Lines 29		$0	($816)	($4,694)	($2,449)
38	**IF remaining MAXDSH is Positive amount**:					
39	The remaining MAXDSH from line 31					$0
40	Hospitals inpatient GA expense from line 2	$17,000	$4,000	$23,000	$12,000	
41	Subtract: ICAs from line 1 for all hospitals	($10,710)	$0	($5,290)	($4,320)	
42	Subtract: DSH prorated in step 1, from line 11	$0	($920)	$0	$0	
43	Subtract: DSH prorated in step 2, from line 19	$0	($520)	($2,990)	$0	
44	Subtract: DSH prorated in step 3, from line 29	$0	($1,080)	($6,210)	($3,240)	
45	Excess GA expense, Line 40 - Lines 41 to 44	$6,290	$1,480	$8,510	$4,440	
46	Total Excess GA expense for all hospitals, Sum of line 45					$20,720
47	Ratio of remaining MAX DSH -to- Excess GA expense, Line 39 / Line 46					0.0%
48	Distribute remaining MAXDSH based on ratio, Lines 47 x 45	$0	$0	$0	$0	
RECAP						
49	DSH Allowance, lines 11+19+29+37+48	$0	$1,704	$4,506	$791	$7,000
50	Inpatient indigent care allowance (ICA) from line 1	$10,710	$ 0	$5,290	$4,320	
51	Total Funding Provided for GA expenses, Lines 49 + 50	$10,710	$ 1,704	$9,796	$5,111	
52	Divide by: Hospital's Inpatient GA expense from line 2	$17,000	$4,000	$23,000	$12,000	
53	Final Ratio, Funding provided -to- GA expense	63.00%	42.59%	42.59%	42.59%	

SECTION 8400
SUPPLEMENTAL PAYMENT FOR MAJOR MANAGED CARE HOSPITAL PROVIDERS
Not in Milwaukee County

Supplemental payments will be provided for any hospital located in Wisconsin which meets the qualifying criteria below. This supplement is only available to hospitals that are a major participant in the state's Medicaid managed care (that is, HMO) initiative. The payments will be subject to the payment limitation of §9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for services provided to Medicaid recipients.

8410 Qualifying Criteria.

A hospital will qualify for this supplemental payment for the rate year if:

(1) qualifies for a disproportionate share adjustment under §5243,

(2) more than 9.0% of the hospital's patient days are for newborns (see below, "For item 2..."),

(3) the hospital is located in a county, other than Milwaukee County, that has or is scheduled to have mandatory or optional enrollment in Medicaid managed care in the rate year beginning July 1, and

(4) for the rate year, the hospital is or becomes a major provider of managed care services to Wisconsin Medicaid Program recipients in the county in which the hospital is located (see below, "For item 4...").

For item 2 above, the ratio of newborn patient days to the hospital's total hospital patient days excluding the newborn patient days must exceed 9.0%. The patient days will be from the hospital's audited cost report used for determining the Medicaid utilization rate for a disproportionate share adjustment under §5243.

For item 4 above, either (1) the hospital must have incurred more inpatient days of service for WMP managed care recipients than any other hospital located in the county during the rate year, or (2) the hospital must have incurred at least 40.0% of the inpatient days of service for WMP managed care recipients provided by hospitals located in the county during the rate year. If neither of these two conditions are met during a rate year, any payments made under this section during the rate year will be recovered from the hospital.

8420 Payment.

The supplement will be paid in a prospectively established monthly amount based on the past Medicaid utilization of the qualifying hospitals. The total amount paid in the rate year cannot exceed the amount of the statewide annual maximum for this supplement.

The statewide annual maximum will be allocated to an individual qualifying hospital according to the following formula where:

d	=	Total Medicaid days, including Medicaid HMO days, for an individual qualifying hospital from the calendar year prior to annual rate update.
D	=	Total Medicaid days, including Medicaid HMO days, for all qualifying hospital in the state from the calendar year prior to annual rate update.
M	=	Maximum for the rate year on annual statewide payments under this supplement.
H	=	The portion of the statewide maximum allocated to the individual qualifying hospital for the rate year.
Formula:		(d ÷ D) x M = H

For the individual qualifying hospital, the portion of the statewide maximum allocated to the hospital (H above) for the rate year will be divided by 12 to establish the monthly supplemental payment for the hospital.

8440 Statewide Maximum

The total statewide annual maximum for the supplemental payment for each rate year beginning on and after year July 1, 1996 shall be $250,000.

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SECTION 8500
Pediatric Inpatient Supplement

Supplemental payments are provided to acute care hospitals located in Wisconsin which provide a significant amount of services to persons under age 18. The payments will be subject to the payment limitation of section 9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

8510 Qualifying Criteria for Pediatric Inpatient Supplement

A hospital qualifies for this pediatric supplement if the hospital meets the following criteria.

1) The hospital is an acute care hospital located in Wisconsin.
2) During the hospital's fiscal year described here, inpatient days in the hospital's acute care pediatric units and intensive care pediatric units of the licensed facility totaled more than 12,000 days. Days for stays in neonatal intensive care units are not included in this determination. The inpatient days are counted for the hospital's fiscal year that ended in the second calendar year preceding the beginning of the rate year. For example, for the rate year beginning July 1, 1998, the hospital's fiscal year that ended in 1996 is used.

8515 Determination of Supplemental Payment

The pediatric inpatient supplement is paid as a monthly amount established according to the following method. A total of $2,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of Medicaid pediatric days as described below.

A qualifying hospital's pediatric inpatient supplement will be determined as follows:

$$\text{Hospital's annual pediatric supplement} = \frac{\text{Medicaid pediatric days for hospital}}{\text{Sum of Medicaid pediatric days of all qualifying hospitals}} \times \$2{,}000{,}000 \text{ Statewide annual funding}$$

$$\text{Hospital's monthly pediatric supplement} = \frac{\text{Hospital's annual pediatric supplement}}{\text{12 Months}}$$

Medicaid pediatric days for the above calculation are a hospital's total covered inpatient days for pediatric Medicaid recipients, including HMO covered pediatric Medicaid recipients, for patient discharges occurring in the rate year that began two years prior to the beginning of the current rate year. (For example, for a current rate year beginning July 1, 1998 the rate year July 1, 1996 through June 30, 1997 is used.) A pediatric patient is a patient that has not attained 18 years of age as of the day of admission. Medicaid pediatric days do not include: (a) days of Medicaid recipient stays that are covered in full or part by Medicare; and (b) days of Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as private hospitalization insurance.

SECTION 9000
PAYMENT NOT TO EXCEED CHARGES

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to WMAP recipients. Overall payments from all sources includes, but are not necessarily limited to, WMAP payments, recipient co-payments, third party liability payments, local and related matching FFP amounts under §8000 and the indigent care allowance of §8230. The state fiscal year is July 1 through June 30. Disproportionate share (under sections 5240 and 8250) in the WMAP payment rates will be added to the allowable charges.

If an individual hospital's overall payments for the period exceed charges-plus-disproportionate share, the WMAP will recoup payments in excess of charges-plus-disproportionate share.